# Attachment D—Private/Employer Insurance Options

**Private/Employer Insurance Options**

If an eligible person has access to employer-sponsored health insurance that provides coverage for physician services, pharmacy and inpatient hospital services, the state may provide the person with a voucher (equal in value to the state's cost of providing service) that can be used to join the employer-sponsored plan. Enrollment in the employer-sponsored plan would be in lieu of receiving benefits through a state contracted health plan.

Childless adults will be required to receive services through a county sponsored health plan if one is available to them or through employer-sponsored health insurance. County plans will provide, at minimum, the services identified in the state's waiver proposal. A county may offer additional services if it chooses to do so and if the additional services are available to all members of the county plan. Employer-sponsored insurance would be purchased with a voucher equal in value to the cost of services in the county plan.

For groups covered with Title XXI funds, to prevent crowd-out of existing employer-sponsored health insurance, the state will require an eligible person (excluding pregnant women) with countable income above 50% of the federal poverty level that has voluntarily dropped employer-sponsored insurance to wait six months before becoming eligible for coverage through the waiver. If the employer-sponsored insurance was involuntarily dropped, e.g., the person lost the job; the six-month waiting period will be waived. A person over 50% of the federal poverty level who has employer-sponsored insurance will be ineligible for services under the waiver.

The application for MIFamily coverage will include a box for applicants to check that wish to enroll in employer-sponsored health coverage in lieu of enrollment in the state provided health plan. Staff operating the voucher program will contact individuals who check the box. Information will then be collected on the employer plan, the employee's share of the cost, eligible persons to be covered under the employer plan, and open enrollment opportunities. The applicant will have the opportunity to discuss the benefits of choosing employer-sponsored coverage versus the state plan coverage so that they may make an informed decision. The applicant will also be provided information regarding his or her responsibilities to maintain coverage through the employer and to report immediately any change related to the employer coverage. Once enrolled in the voucher program, the beneficiary will receive a monthly check for the amount of the employee share of the coverage obtained or the cost of placing the eligible beneficiaries in a state offered health plan, whichever is less.

To ensure the employer-sponsored coverage is actually purchased by the beneficiary, the state will do tape matches with the state's largest insurer (Blue Cross and Blue Shield of Michigan (BCBSM)) and will audit a sample of cases where BCBSM is not the employer's carrier. Those selected in the audit sample will be required to provide copies of pay stubs or other verification that all eligible beneficiaries are enrolled as agreed upon

between the state and the beneficiary. Person's who are found not to have purchased the employer-sponsored coverage as agreed will be required to pay back the amount received in premium assistance for months where the coverage was not in place. The beneficiary will also be excluded from future participation in the voucher program.

To ensure that the cost of the employer-sponsored coverage does not exceed the cost of providing coverage through a health plan under contract with the state Medicaid program, staff will monitor the cost of buying in on a per beneficiary level. The cost of buying in to the employer-sponsored coverage will be compared with the cost to the state and federal governments of purchasing coverage through a contracted health maintenance organization. If the employer-sponsored coverage is more expensive than the monthly payment the state would make to one of its health plans, the beneficiary will not be allowed to buy-in. If the cost of buying in is less than or equal to the payment the state would have made to the health plan, the beneficiary will be allowed to buy in to the employer-sponsored coverage. If the beneficiary is buying in to employer-sponsored coverage for the beneficiary and the beneficiary's eligible spouse, the payment that the state would have made to a health plan to enroll both parents will be compared to the cost of buying in. The state's monitoring of each buy-in decision will ensure the cost effectiveness of the buy in program and ensure that the costs to the federal government are no greater than they would have been without the buy in.